calculate the indexed adjusted cost for the provider.

(ii) For purposes of calculating rates for rate year 1997, the DRI index is applied by multiplying the provider's adjusted base period cost by 10.2% to calculate the indexed adjusted cost for the provider.

(iii) For purposes of determining rates for the 1998 and subsequent rate years, the DRI index is the most recent DRI index available as of the May 1st immediately preceding the rate year, applied by indexing the provider's prior rate by the change in value of the average index from the prior rate year to the new rate year expressed as a percentage. The result is the indexed adjusted cost for the provider.

(e) "Established provider" means a currently participating provider that is not a new provider.

(f) "Indexed adjusted cost" means the provider's adjusted base period per diem cost indexed by the applicable DRI index as specified in these rules.

(g) "New provider" means a provider that did not participate in the Montana medicaid program as a residential treatment services provider during the base period.

(h) "Rate year" means the state fiscal year, i.e., from July 1 through June 30. Rate years are designated by the calendar year in which the period ends. For example, rate year 1998 is the period from July 1, 1997 through June 30, 1998.

(I) "Statewide rate" means the medicaid bed-weighted average of the indexed adjusted cost for all established Montana providers. For purposes of calculating the statewide rate, the department uses annualized medicaid bed days from all established Montana providers for the most recent rate year for which data is available from all established Montana providers.

(4) For services provided during the 4th quarter of state fiscal year 1996 or rate year 1997 the provider's per diem payment rate is an amount equal to 95% of the provider's indexed adjusted cost.

(5) For services provided during rate year 1998 the provider's per diem payment rate is the lesser of an amount equal to the provider's indexed adjusted cost or the blended rate.

(6) For services provided during rate year 1999 and subsequent rate years the provider's per diem payment rate is the lesser of an amount equal to the provider's indexed adjusted cost, or the statewide rate.

(7) The final per diem payment rate for new providers is $249.41 for services provided during the period April 1, 1996 through June 30, 1996 and $255.00 for services provided during the period July 1, 1996 through June 30, 1997. The new provider rate for services provided during the period July 1, 1997 through June 30, 1998 will be the amount of $255.00 indexed by the DRI index. Effective beginning July 1, 1998, the final per diem rate for new providers will be the statewide rate. No retrospective cost settlements will be performed.

(8) The prospectively determined rates provided in these rules are all-inclusive bundled rates. Except as provided in (8)(a), (b) and © the

per diem payment rate covers and includes all psychiatric services, all therapies required in the recipient's plan of care, and all other services and items related to the psychiatric condition being treated, that are provided while the recipient is admitted to the residential treatment facility, including but not limited to services provided by psychologists, social workers, and licensed professional counselors, and lab and pharmacy services. These services must be reimbursed from the provider's all-inclusive rate except as provided in (8)(a), (b) and (c) and are not separately billable.

(a) The professional component of physician services is separately billable according to the applicable rules governing billing for physician services.

(b) Services and items that are not related to the recipient's psychiatric condition being treated in the residential treatment facility and that are not provided by the residential treatment facility are separately billable in accordance with the applicable rules governing billing for the category of services or items.

(c) Community licensed professional counselors, social workers and psychologists may bill separately for telephone conferences for purposes of remaining informed about the recipient's progress and for discharge planning. These providers may not bill separately for treatment provided while the recipient is admitted to the facility.

(9) The prospectively determined rates provided in these rules are the final rates, and rates will not be adjusted retrospectively based upon more recent cost data or inflation estimates. Cost settlements will not be performed.

(10) Payment for residential treatment services provided outside the state of Montana will be made only under the conditions specified in the State Plan, [redacted]. Reimbursement for residential treatment services provided to Montana medicaid recipients in facilities located outside the state of Montana will be reimbursed a percentage of the provider's usual and customary charges. The percentage shall be the provider's cost to charge ratio determined by the facility's medicare intermediary or by the department under medicare reimbursement principles, based upon the provider's most recent medicare cost report. If the provider does not submit the medicare cost report and other financial information necessary to determine the cost to charge ratio, the percentage will equal 60% of the provider's usual and customary charges.

(11) For facilities located outside the state of Montana, the department may set an interim rate and pay for services using the interim rate until sufficient information has been submitted to determine the provider's final rate under (10). The interim rate shall be 60% of the provider's usual and customary charges. If the department pays using an interim rate or, if the department pays for services at a rate determined under (10) but subsequently obtains additional information necessary to fully apply (10), the department may settle the rates and adjust any

overpayment or underpayment in accordance with ARM 46.12.595.

(12) Reimbursement will be made to a provider for reserving a bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit;

(c) the recipient is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department or its designee determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence.

(13) No more than 14 days per recipient in each rate year will be allowed for therapeutic home visits.

(14) The provider must submit to the addictive and mental disorders division or its designee a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a recipient leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the addictive and mental disorders division or its designee.

(15) Providers must bill for residential treatment services using the revenue codes listed in the department's residential treatment services provider manual. The department must provide 30 days prior written notice to providers of any changes in revenue codes.

46.12.593 RESIDENTIAL TREATMENT SERVICES, COST REPORTING AND AUDITS (1) For cost reporting purposes, allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of certified public accountants, subject to the provisions of the Medicare Provider Reimbursement Manual (HCFA-Pub. 15) except where further restricted in this administrative rule. The department hereby adopts and incorporates by reference the Medicare Provider Reimbursement Manual (HCFA-Pub. 15), which is a manual published by the United States department of health and human services, social security administration, which provides guidelines and policy to implement medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the Medicare Provider Reimbursement Manual (HCFA-Pub. 15) may be obtained through the Department of Public Health and Human Services, Health Policy and Services Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) Return on equity capital is not an allowable cost.

(b) Bad debt expense is not an allowable cost.

(c) Educational and vocational training costs are an allowable cost if such costs qualify for federal financial participation under the provisions of 42 CFR 441.13(b), as amended effective December 21, 1992.

(2) For purposes of calculating allowable capital costs for cost reporting purposes, the number of days of service shall be the greater of:

(a) actual days of service; or

(b) days of service representing 80% occupancy.

(3) The facility must record and report costs in accordance with these rules and generally accepted accounting principles as defined by the American institute of certified public accountants. The facility must maintain appropriate accounting records which will enable the facility to fully complete the cost report in the form required by the department.

(4) Providers must use the accrual method of accounting for recording and reporting costs, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(5) Cost finding means the process of redistributing the data derived from the accounts ordinarily kept by a facility to ascertain its costs of the various services provided. Cost finding is the resolution of the costs by allocation of direct costs and proration of indirect costs. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 which the department hereby adopts and incorporates by reference. 42 CFR 413.24 [redacted] is a federal regulation setting forth methods of cost finding. A copy of the regulation may be obtained from the Department of Public Health and Human Services, Addictive and Mental Disorders Division, PO Box 202951, 1400 Broadway, Helena, MT 59620-2951.

(6) Provider costs must be reported based upon the provider's fiscal year using the financial and statistical report form provided by the department. The use of the department's financial and statistical report form is mandatory for participating facilities. These reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction. The department will not accept or use for any purpose a cost report for any period greater than 12 months.

(a) The provider must file its cost report and supporting documents with the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period. Extensions of the due date for filing a cost report may be granted by the intermediary only when a provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control, such as flood or fire.

(b) In the event a provider does not file a complete cost report complying with these rules as required in (6)(a)) above or files an incomplete cost report, the provider's total reimbursement will be withheld. All amounts so withheld will be payable to the provider upon sub-

mission of a cost report which complies with these rules.

(c) Failure to submit a cost report will result in recovery by the department of all amounts paid by the department for the fiscal year covered by the cost report.

(d) Cost reports must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider or an authorized officer of a corporate provider. The person executing the reports must sign under penalties of false swearing, that he has examined the report including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared consistent with governing laws, regulations and accounting principles.

(7) Records of financial and statistical information supporting cost reports must be maintained by the provider and the department for 3 years after the date a cost report is filed, the date the cost report is due or the date upon which a disputed cost report is finally settled, whichever is later.

(a) Each provider must maintain, as a minimum, a chart of accounts, a general ledger and the following ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable, cash disbursements, payroll, general journal, resident census records identifying the level of care of all residents individually, all records pertaining to private pay residents and resident trust funds.

(b) Business records of any related party, including any parent or subsidiary firm, related to a provider must be available at the facility to support allowable costs. The owner's or related party's personal financial records relating to the facility also must be available at the facility to support allowable costs. Any costs not so supported will not be allowable.

(8) The department or its designee may perform a desk review of cost reports and may conduct on-site audits of provider records. Audits will meet generally accepted auditing standards as defined by the American institute of certified public accountants.

(a) Cost information as developed by the provider must be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedures. The information which may be used to document costs must include all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks, invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. Documentation created after the fact will not be sufficient to support such costs.

(b) All of the above records and documents must be available at the facility at all reasonable times after reasonable notice and subject to inspection, review or audit by the department, the federal department

of health and human services, the Montana legislative auditor, and other authorized governmental agencies.

(c) Upon refusal of the provider to make available and allow access to the above records and documents, all payments made by the department during the provider's fiscal year to which those records relate shall be recovered in full by the department.

(9) In addition to the requirements of (8), the department may require out-of-state providers to submit a copy of their most recent audit report in those instances where the provider has not prepared or is not required to prepare a HCFA form 2552. The audit report must have been performed in accordance with generally accepted auditing standards as defined by the American institute of certified public accountants.

46.12.595 RESIDENTIAL TREATMENT SERVICES, COST SETTLEMENT AND UNDERPAYMENT (1) For facilities located outside the state of Montana, the department may, as provided in (2), perform cost settlements and correct overpayments and underpayments.

(2) The department may determine, through the cost settlement process, whether overpayments or underpayments have resulted to out-of-state providers receiving Montana medicaid reimbursements in excess of $50,000 per year.

46.12.597 INPATIENT PSYCHIATRIC SERVICES, ADMINISTRATIVE REVIEW AND FAIR HEARING PROCEDURES A recipient will have the right to administrative review and fair hearing for any service denied as not being medically necessary.

46.12.599 RESIDENTIAL TREATMENT SERVICES, CERTIFICATION OF NEED FOR SERVICES, UTILIZATION REVIEW AND INSPECTIONS OF CARE (1) Prior to admission and as frequently as the department may deem necessary, the department or its agents may evaluate the medical necessity and quality of services for each medicaid recipient.

(a) In addition to the other requirements of these rules, the provider must provide to the department or its agent upon request any records related to services or items provided to a medicaid recipient.

(b) The department may contract with and designate public or private agencies or entities or, a combination of public and private agencies and entities, to perform utilization review, inspections of care and other functions under this rule as an agent of the department. Any contracted or designated agent must comply with the requirements of this rule. The department must give residential treatment services providers advance written notice of a change in the designated agent. When a notice is required by this subsection, the notice must specify the scope of the agent's duties, the geographical area of the agent's authority and the agent's name, address, telephone number and facsimile number.

(2) Medicaid reimbursement is not available for residential treatment services unless the provider submits to the department's

utilization review agent in accordance with these rules a complete and accurate certificate of need for services that complies with the requirements of 42 CFR part 441, subpart D and these rules.

(a) For recipients determined medicaid eligible by the department as of the time of admission to the facility, the certificate of need must:

(I) be completed, signed and dated prior to, but no more than 30 days before, admission; and

(ii) be made by an independent team of health care professionals that includes a physician, that has competence in diagnosis and treatment of mental illness, preferably in child psychiatry and that has knowledge of the recipient's situation, including the recipient's psychiatric condition.

(b) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the certificate of need must:

(I) be completed, signed and dated within:

(A) 14 days after the eligibility determination for recipients determined eligible during the stay in the facility; or

(B) 90 days after the eligibility determination for recipients determined eligible after discharge from the facility;

(ii) cover the recipient's stay from admission through the date the certification is completed; and

(iii) be made by the facility team responsible for the recipient's plan of care as specified in 42 CFR 441.155 and 441.156 (1994).

(c) All certificates of need must actually and personally be signed by each team member, except that signature stamps may be used if the team member actually and personally initials the document over the signature stamp.

(3) Providers must request admission or initial authorization and continued stay authorizations from the department's utilization review agent for each recipient. Medicaid reimbursement is not available for residential treatment services if the portion of the recipient's stay at the facility for which reimbursement is claimed has not been authorized by the department's utilization review agent.

(a) Prior to admission of a medicaid recipient, the provider must submit to the department's utilization review agent a request for admission authorization and must submit the required certificate of need and supporting documentation. The request, certificate of need and supporting documentation must be received by the department's utilization review agent prior to admission.

(b) For recipients determined medicaid eligible by the department after admission to or discharge from the facility, the provider must submit to the department's utilization review agent a request for an

initial authorization and must submit the certificate of need and supporting documentation. The request, certificate of need and supporting documentation must be received by the department's utilization review agent within 14 days after the department's eligibility determination.

(c) For additional periods of the recipient's stay after the period covered by the initial or admission authorization, the provider must request a continued stay authorization and must submit supporting documentation. The request and supporting documentation must be received no more than 5 and no less than 2 working days before the end of the previous authorized span.

(4) The department's utilization review agent must review an admission or initial authorization request or a continued stay authorization request, make a determination on the request and notify the provider and the recipient's parent or guardian of any determination within 3 working days of receipt of a request, unless the provider has not submitted the documentation or information necessary to make a determination. The agent must transmit authorization information regarding authorized spans to the department's fiscal agent within 3 working days of a determination.

(a) If the provider's request is incomplete, the agent must notify the provider, within 1 working day of receipt of an incomplete request, that the request is incomplete and must identify the additional information or documentation necessary to make a determination. Notification of an incomplete request by the agent to the provider is not required if the provider's request indicates that the provider will be sending additional documentation or information to support the request, in which case the burden shall be upon the provider to submit the additional documentation or information or to notify the agent in writing that nothing further will be sent and that the provider requests the agent to make a determination upon the request as submitted.

(5) If the department's utilization review agent in whole or in part denies an admission or initial authorization request or a continued stay authorization request, the provider or the recipient's parent or guardian may within 10 days of the date of the mailing of the notice request that the department's utilization review agent conduct an informal reconsideration of the determination. The agent may include in the informal reconsideration a peer-to-peer review and must include a peer-to-peer review if requested by the provider in its request for informal reconsideration. A peer-to-peer review must be held within 10 days of the request for informal reconsideration, but may be held at a later time with the agent's and provider's mutual written consent.

(a) The agent may request additional supporting information or documentation. The information and documentation presented by the

provider may include only information documented in the facility's records.

(b) The agent must make a determination on the informal reconsideration and notify the provider and the recipient's parent or guardian of the determination within 3 working days after the agent has received the written request and supporting documentation, including any additional documentation or information requested by the agent and has completed the peer-to-peer review, if any.

(c) A provider, parent or guardian dissatisfied with the determination on informal reconsideration may request an administrative review and fair hearing according to the provisions of ARM 46.12.597. A provider or a recipient's parent or guardian that does not timely request an informal reconsideration will be deemed to have accepted the agent's determination and is not entitled to any further notice or appeal opportunity.

(6) The requests, submissions and notifications required by this section must be made as follows:

(a) Providers must make the required notifications, submissions and requests to the department's utilization review agent by facsimile transmission or overnight mail.

(b) The department's utilization review agent must notify the provider and the recipient's parent or guardian in writing of any determination on an initial authorization request, a continued stay authorization request, an informal reconsideration request or an administrative review request. A notice must be addressed separately to the provider and to the recipient's parent or guardian. The agent must transmit the provider notice by facsimile and send the original to the provider by U.S. mail. The agent must notify the recipient's parent or guardian by U.S. mail.

(c) A notice of an adverse determination under subsection (6)(b) must contain the following:

(I) the recipient's name and medicaid identification number as reported to the agent by the provider;

(ii) a statement of the determination, including the specific dates necessary to identify any period authorized or denied and the date of the determination;

(iii) a short and concise statement of the reasons for the denial, if any;

(iv) a reference to the legal authority supporting the determination; and

(v) an explanation of how to appeal the determination.

(d) If the agent fails to provide notice or fails to timely provide notice or if a notice required by subsection (6)(b) fails to comply substantially with the requirements of subsection (6)(c), the remedy

shall be provision of a new notice which does comply substantially with subsection (6)(c) and a new opportunity to contest the determination specified in the notice. A failure to give adequate or timely notice under subsection (6)(b) or (6)(c) shall not entitle the provider or recipient to an authorization. A provider or recipient is not entitled to an authorization absent a showing and determination of medical necessity.

(7) When required to be submitted under this rule, supporting documentation includes all or any portion of the facility's records as necessary to demonstrate the medical necessity of residential treatment services and where the context allows, includes a certificate of need conforming with the requirements of (2).

(8) Providers must maintain written documentation of authorization requests submitted under this rule, including but not limited to certificates of need, written request letters or memoranda and evidence of submission dates.

(9) Medicaid reimbursement is not available for any portion of a medicaid recipient's stay in a facility that occurs prior to meeting the requirements of (3) through (3)(c).

(10) If the department's utilization review agent fails to timely review a request for authorization or timely make a determination on an authorization or informal reconsideration request, the provider may make written inquiry to the agent regarding the status of the matter. If the provider does not receive a satisfactory response within a reasonable time, the provider may contact the Department of Public Health and Human Services, Addictive and Mental Disorders Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210 for assistance is obtaining a determination.

(11) An authorization by the department or its utilization review agent under this section is not a final or conclusive determination of medical necessity and does not prevent the department or its agents from evaluating or determining the medical necessity of services or items at any time.

(12) In accordance with 42 CFR part 456, subpart I (1994), the department or its agents may conduct periodic inspections of care in residential treatment facilities participating in the medicaid program.